Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL384123080M
Compliance #: HL384123000C

Date Concluded: August 28, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Burnsville
1880 134th St E
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident resulting in an unwitnessed fall and sustained a fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained an injury, the facility had appropriate interventions in place to prevent falls and/or injury. While the resident wandered the unit continuously the staff members had provided safety checks, was aware the resident was at risk for falls, and contacted nursing to send resident to emergency department for evaluation appropriately when the fall occur

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's service plan, assessments, progress notes,

hospital records, and facility internal investigation. Also, the investigator completed an onsite visit to observe resident to staff interactions and the resident's mobility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, osteoporosis, and multiple mental health issues. The resident's service plan included even though the resident chose to ambulate independently, the staff members were to encourage resident to use walker. The resident was also encouraged to sit and rest when exhibiting signs of weakness and instability. The resident was unable to understand and/or follow directions and required frequent cues and reminders. The resident demonstrated inappropriate judgment related to safety including refusals to use a walker. The service plan also indicated fall interventions to include keeping the resident's room clutter free, clear all pathways, wear proper footwear, offer the bathroom, and safety checks.

The resident's individual abuse prevention plan dated five months prior to the fall indicated the resident was vulnerable to falls related to her chronic back pain which may cause her to become unstable while ambulating. The resident does have a walker but refuses to use it as she forgets to use the walker as the walker is not familiar to the resident even with caregiver reminders. The resident could become agitated with staff or raise her voice with caregivers when she became frustrated.

Progress notes indicated resident was evaluated by psychiatry/behavioral health. The same document indicated the resident at times refused care and safety checks were required every 2 hours. Overnight the resident had a history of wandering and tended to nap during the day.

To address the resident's fall risk, the facility completed a risk assessment. The resident exhibited normal gait but with her diagnosis of dementia did not always know her limits and was at high risk for falls.

An incident report indicated during an overnight safety check the staff found the resident on the floor in her room. Staff notified the nurse on call of the incident and were instructed to send the resident to the emergency department for evaluation.

The emergency department records indicated the resident had a leg bone fracture that required surgical repair. After the surgery, the resident returned to the facility after about five days.

During an interview, multiple facility nurses stated the resident continuously walked and paced the unit. The resident had experienced a fall the previous day with no injury. Multiple nurses stated previous attempts of PT/OT had been attempted but unsuccessful. Caregivers did direct the resident to use her walker, however; the resident would either drag or carry the device placing her at yet further risk for a fall.

During an interview, an unlicensed caregiver stated the resident wanders the unit and visits with people. The caregiver stated the resident generally did not use the walker.

During an interview, a family member stated the resident would not use the walker as this was not something she used prior to her diagnosis of dementia. The family member stated the resident wanted to complete tasks on her own and the fall occurred because the resident having both of her legs in one leg of her pajama bottoms causing her to lose her balance and fall. The family member stated even prior to her diagnosis of dementia, the resident went for long walks all the time.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect. (a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action required.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38412	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF BURNSVILLE	1880 134TH STREET EAST BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL384123080M/HL384123000C HL384124262M/ HL384124996C On July 18, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 28 Residents receiving services under the provider's Assisted Living with Dementia Care license. No correction orders are issued.	0 000		